Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2912HPC	A. BUILDING _____ B. WING _____	11/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAHOE FORST HOSPICE	2092 LAKE TAHOE BLVD #500 CAVE ROCK, NV 89448

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS Surveyor: 22046 This Statement of Deficiencies was generated as a result of a State Licensure resurvey conducted in your facility on 11/3/09 and finalized on 11/4/09, in accordance with Nevada Administrative Code, Chapter 449, Provision of Hospice Care. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Three patient records were reviewed. No home visits were conducted. Six employee files were reviewed.	L 000		
L 056 SS=A	449.0184 GOVERNING BODY REQUIRED; DUTIES OF GOVE Section 19 Every facility which provides a program of hospice care must have a governing body which shall: 1. Appoint an administrator of the program of hospice care. The administrator shall be available on a daily basis for consultation with members of the interdisciplinary team of the program of hospice care.	L 056		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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L 056	Continued From page 1 This Regulation is not met as evidenced by: Surveyor: 22046 Based on staff interview and review of governing body minutes, the facility failed to provide proof of the governing body's appointment of an administrator of the program of hospice care. Severity: 1 Scope: 3	L 056		
L 069 SS=A	449.0186 REQUIREMENTS FOR PLAN OF CARE 2. A plan of care must: (c) State the scope and frequency of each service to be provided to the patient and members of his family. This Regulation is not met as evidenced by: Surveyor: 22046 Based on clinical record review and staff interview, the agency failed to provide services as ordered by the physician and identified by the interdisciplinary group by providing less than two nursing visits per week when a range of one to two visits per week was ordered for 1 of 3 sampled patients. (Patient #2) Severity: 1 Scope: 1	L 069		